IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF OKLAHOMA

WILLIAM RAY SPRAY, JR., and RHONDA JEAN SPRAY, Individually and as Personal Representatives of the Estate of SINDI LUCILLE SPRAY, Deceased,	)	
Plaintiffs,	)	
vs.	)	NO. CIV-20-1252-C
BOARD OF COUNTY COMMISSIONERS OF OKLAHOMA COUNTY, in its Official Capacity as Governing Body of the County of Oklahoma County,	)	
Defendant.	)	

DEPOSITION UPON ORAL EXAMINATION OF

RYAN D. HERRINGTON, M.D.

May 23, 2023
Olympia, Washington
Pages 1 through 140

Reported by Karyn Kirouac, CCR #2471

clinical practice.

Q. Have you ever talked to the Oklahoma Medical Board about that and what they would do to a doctor -- strike that.

Have you ever talked to the Oklahoma Medical Board about their position on a physician making a medical diagnosis without examining the patient?

A. Can you give me the diagnosis that was made.

Q. Any diagnosis.

A. Including on-call physician for patients in withdrawal and so forth?

Q. As far as making a diagnosis.

A. It can be acceptable under certain circumstances.

Q. You think that the Oklahoma Medical Board would accept that?

A. I don't know.

Q. And do you have any knowledge of whether or not a physician's assistant in the state of Oklahoma can make a medical diagnosis, even attached to the license of a doctor, without physically seeing the patient?

A. It depends on clinical circumstances and the diagnosis that is made.

Q. Are you aware if the state of Oklahoma will accept that?

A. I don't know.
Q. Are you aware if the state of Oklahoma will accept a nurse practitioner formulating a diagnosis without ever seeing the patient?
A. I think it depends on circumstances, and it depends on the diagnosis and the patient's condition.
Q. So my question asked if you know if the state of Oklahoma will accept that. Do you know?
A. I don't know.
Q. Doctor, I'm going to hand you what I've marked as Exhibit 39, which is a document that I found online that has your picture and your name, I'm assuming, but I'm going to ask you have you seen this before?
A. Yes.
Q. Why don't you just tell us for the record what this is.
A. This is a profile.
Q. I'm sorry?
A. This is a profile.
Q. That's online concerning you?
A. Correct.
Q. It's telling the world that you're available as an expert witness, which is correct, is it not?
A. Correct.
Q. And this is through SEAK, S-E-A-K, Inc.; is

on the list?

Q. Let's see.

MS. REMILLARD: I have a copy here.

Q. (BY MR. SHADID) It's in the little book. I think it's number -- no. I believe it's number 7. I'm just asking if that's what you were referring to.

A. Yes.

Q. Okay. On number -- down at line 34, the documents reviewed, it says Turn Key Case Review. I think I know which document you're referring to. I'll pull it up to be sure. It was number 25. Exhibit 25 is labeled Sentinel Event Review. Is that what you're referring to as being the Turn Key case review?

A. Yes.

Q. Okay. I just want to be sure that we're talking about the same thing, because we will talk about it a little bit more.

A. Can we do just a quick few minutes?

Q. Sure. Sure.

(Recess from 11:57 a.m. to 12:04 p.m.).

Q. (BY MR. SHADID) Doctor, on page 6 of your report, the top of the page, it still has things that are listed that you reviewed or at least -- yeah, that says you reviewed. Line 2 talks about phone call recordings by Ms. Spray. Were they relevant to your opinion in any way?

A. Ms. Spray called her grandmother. What I remember from that is the patients that I have seen that have actively perforated an ulcer are not comfortable enough to be on the phone, if that makes sense.

Q. Were you suggesting that you believe she did not have a perforated ulcer at that time?

A. No. My belief is that she perforated her ulcer prior to being booked. That's what my belief is. And it's an unusual presentation for that diagnosis.

Q. I'm trying to correlate that with you said you usually don't feel comfortable being on the phone.

A. It's not they're uncomfortable being on the phone. If you've seen a patient with an acute surgical abdomen, it's an impressive thing to see clinically, and the patients are profoundly uncomfortable.

In fact, oftentimes we'll ask them about the car ride on the way to the hospital: Did the bumps on the road bother your abdomen?

And so the point I'm trying to make is those patients are usually very uncomfortable. And when I heard her voice, it sounded like a conversation that I would hear for someone who's not at that level of discomfort, is what I tried to say.

Q. You believe that she was -- that her duodenal was perforated before she was booked in, but the phone --

the conversations you heard were not really consistent with what you would normally expect in terms of the way she sounded as far as being in agony or pain?

A. From the surgical -- from an acute surgical abdomen, yes.

Q. Now, while we're on that subject, why do you think that the perforation happened before she was booked in?

A. The reason I think that is I didn't see a presentation of an acute surgical abdomen while she was at Oklahoma Detention Center. I never saw any documentation that was suggestive of that development.

Q. What you call an acute abdomen?

A. Correct. So that's what I was looking for.

Q. What symptoms would you be looking for?

A. So I'm looking for somebody who's very uncomfortable, particularly with their abdominal examination. When you put your hands on these patients and you press inwards and then you pull your hands away kind of quickly, that maneuver is enough to irritate the peritoneum, and the patients complain of pain.

Q. What else would you be looking for?

A. Well, I mean you would take a history first.

Q. For what you call an acute abdomen, you would take --

7a86ef18-a827-4a20-b22d-98ec86f5c01b

A. Vital signs; you would ask for what medicines they take.

Q. Anything else, Doctor?

A. Medicines, when the pain started, what makes it better or worse, what you've done for it before, have you had this before, what operations have you had, are you passing gas and stool.

There's a whole host of questions you can go through, but what I'm looking for is somebody that presents with significant abdominal pain and an examination that's abnormal. That's kind of what I'm looking for. And because I didn't see that in Ms. Spray's file, I don't think she had a surgical abdomen. And then 1,400 --

Q. Surgical or acute?

A. Same. I use the term interchangeably.

Q. You didn't see what?

A. So I didn't see an acute abdomen presentation in her file, and that impacted my opinion very substantially.

And then her postmortem finding of 1,400 MLs, I saw that as a very large amount of volume of fluid, and the reference was made to seepage. So I didn't think that the fluid was leaving the intestinal system quickly. So I took the absence of an acute abdomen, and I took this

7a86ef18-a827-4a20-b22d-98ec86f5c01b

seepage language that the medical examiner used, and determined that on a more-likely-than-not basis that 1,400 milliliters had to accumulate slowly over time.

Q. I should have asked you this earlier: You're not trying to blame the pathologist, right?

A. I'm not a pathologist, but I'm a very good primary care doctor and a very --

Q. A very good primary care doctor that's not board certified, correct?

A. No. I'm boarded in preventive medicine in addition --

Q. In primary care.

A. I'm not boarded in primary care. So I don't feel that I was outside the scope of my expertise in saying what I just said.

Q. On the symptoms that you just referred to regarding acute abdomen, you said uncomfortable with abdominal examination. You would do palpations?

A. I would, yes.

Q. That never happened to Sindi Spray, did it?

A. I did not see a provider palpate her abdomen, that is correct.

Q. Are you able to tell us what the causes of a duodenal ulcer is?

A. We usually think of infection with a

7a86ef18-a827-4a20-b22d-98ec86f5c01b

rectum, can you take it out. So we don't do that. We don't do that kind of exam.

Another example might be a patient who's actively seizing for no reason after hours, and I get a phone call. I'm not going to delay definitive treatment so that I can drive to the prison and do an examination.

Q. You're not going to send them to the ER?

A. No, I'm going to send them to the ER.

Q. You're not?

A. I would.

Q. You would? That's different.

A. No, that was your question. You asked me if there was situations where you don't need to do an exam. And when you can arrive at an appropriate treatment plan for your patient that's in your patient's best interests --

Q. Doctor, when you send somebody to the ER, somebody is doing an exam, are they not?

A. They would do an exam at the ER.

Q. Correct. I asked you whether there's any peer-reviewed materials that say that it's okay to not do an examination.

A. I think you could find something somewhere that is very consistent with what I just said.

Q. Have you found anything that says it's okay to

not examine patients?

A. I've never looked, because I've never had to.

Q. And outside of an emergency situation -- when you have an emergency situation, you send them to the ER, don't you?

A. I do.

Q. Nobody sent Sindi Spray to the ER, did they?

A. No.

Q. And on December 16th, at least by noon or thereabouts, she was complaining of severe abdominal pain, burning, wasn't able to stand up on her own, had to be dragged back to her bunk, and she had previously had some up and downs on the heart rate. As you've said, she was clearly tachycardic. And no doctor ever saw her. That is true, is it not?

A. No doctor saw her, that's true. I'd like to ask if you could show me where you saw abdominal pain.

Q. Okay. You're the reviewing expert. You didn't see that in this chart?

A. I didn't.

Q. Well, let's look -- it's on Exhibit 17. Let's start there.

MS. REMILLARD: Can you refer to the Bates number, because I don't have your exhibit.

MR. SHADID: Oh, I'm sorry.

see a surgical abdomen.

Q. Whether you see a specific thing or not, when complaints happen should the patient's complaints be listened to?

A. Yes.

Q. And when she told Ginger Vann and Ginger Vann reported that she was having stomach pain, that she was having burning in her chest or abdomen, couldn't even walk, should that have been paid attention to?

A. Yes.

Q. And it wasn't, was it?

A. So the reason I think that the Turn Key folks and the county, I think that their care of this lady was not a cause or an explanation for her passing, is that they recognized that she had opiate withdrawal and they monitored her for that and they gave her appropriate treatment for that.

It's unlikely that she would present with a second problem at the same time that didn't present in the usual way. So my opinion is that Ms. Spray had two problems: One that presented in the usual way that was recognized and monitored and treated; the second one didn't present in the usual way, and she didn't have a history of peptic ulcer disease anyway.

So I didn't find evidence that that condition

which is ultimately what killed her, I didn't find evidence in my review that there was enough information or clinical suspicion that would warrant somebody thinking about that diagnosis.

Q. So back to my question: When she complained of abdominal pain, burning, and not being able to stand up, and it was reported to nurse Hadden, she didn't do anything, did she?

A. I don't -- I didn't see that she did anything.

Q. She did not respond to those complaints, did she?

A. I don't -- I don't remember.

Q. She said: Well, I saw her earlier this morning and she's fine, something to that effect?

A. That's what I remember.

Q. And then nurse Hadden post-death wrote a chart entry. Did you see that?

A. I did, but I'd like to see it.

Q. I'll show it to you. On page -- actually it appears more than once, but on page 75, that's one of the entries, and it's a few other places. Let's see. To be more precise, it's on 106.

A. Okay.

Q. It's under the heading of chart notes, which is why I was asking you earlier what you consider to be the

Board, then.

A. Sure.

Q. Because I'm sure you have no idea how many doctors I've defended who didn't see patients.

A. Mr. Shadid, I'm very confident in the opinions I've given in this report.

Q. I understand you're confident. A nurse can't make a diagnosis, can they?

A. That's correct.

So one thing we might be looking at here is the standard of care doesn't require that a patient see a provider right away once they enter the correctional facility.

Q. Doctor, I have a limited amount of time. I've got to be out of here in an hour. My question is who made a working diagnosis?

MR. SHADID: I want this time stamped. Can you do that?

(The time noted was 1:13 p.m.).

Q. (BY MR. SHADID) Go ahead, Doctor.

A. The working diagnosis for this case would have been made by the -- I think she was a nurse practitioner who received a phone call about Ms. Spray the evening of the 14th of December.

Q. Where are you looking, Doctor?

A. I am looking on page 9 of my report.
Q. Separate from your report, where in the records are you referring to where anybody made a diagnosis?
A. Well, I don't think it appears in the chart yet, because she expired. Had she been seen for her history and physical, somebody would have diagnosed opioid withdrawal.
Q. Somebody would have done it, but it hadn't happened. And you just put down here that she was -- you said, at line 13 on page 5, that they had every reason to be confident in their working diagnosis, and I want to know what that working diagnosis was.
A. So she came in and on her intake screening she said she took heroin, one and a half grams a day, and she gets put on a monitoring system.
Q. Got all that. I just want to know who -- don't fill up the record with other stuff. The question's very simple. What provider made a working diagnosis of anything?
A. So it would have been the provider that answered the phone call the evening of the 14th.
Q. Show me.
A. Well, I don't think she wrote a note on it.
Q. Well, then you don't know that it happened if she didn't write a note.

A. No, but on a more-likely-than-not basis, she did because I've received these exact same phone calls. I've made the exact same working diagnosis.

Q. You're speculating that she did?

A. I don't think I'm speculating. I think it's more than 50 percent.

Q. You don't see anything in the record where there is a diagnosis of anything, do you?

A. I would have if she had lived to her medical -- to her intake physical, history and physical.

Q. Let's go back to the question. You don't see anything in the record that shows that anybody made a diagnosis, do you?

A. There's no chart note that says diagnosis, opioid use disorder, opioid withdrawal.

Q. Or anything else, correct?

A. I don't see a note that says that.

Q. Why do you think, as you stated at page 4 of your opinion, that the theme of the case relates to how the patients were processed?

A. Where are you now?

Q. On page 4 of your opinion.

A. Of the original report?

Q. Yes, sir.

A. That's 36?

Q. How often are detox checks supposed to happen?
A. It depends on the severity of the withdrawal.
Q. How often should detox checks have happened for Sindi Spray?
A. She had twice a day. And your question is how often should she have --
Q. How often should they have them?
A. So I don't think she was under-monitored. I know that's not exactly your question.
Q. No, my question is how often should it have happened?
A. You could have ordered twice a day, you could have ordered three times a day to start, and sort of see how she trended and adjust accordingly.
Q. Is 19 hours apart okay?
A. That's long.
Q. Is 22 hours apart okay?
A. That's long.
Q. What about 16 hours?
A. That's long.
Q. If a patient inmate requests medical care, is it okay for a nurse to refuse it?
A. No.
Q. Is it okay for a nurse to not complete a set of vital signs when assessing a patient for presumed opioid

withdrawal when the complaints now exist -- now include shortness of breath?

A. No. There should be a set of vital signs.

Q. When a complaint is made to the director of nursing regarding an inmate's patient care, is it okay for the director of nursing to not pass that on to the health services administrator?

MS. REMILLARD: Object to form.

THE WITNESS: I don't know that a nursing director would have to pass something on to the health services administrator. If that's a clinical patient encounter, I think you treat that as a patient encounter and take care of your patient.

Q. (BY MR. SHADID) If a staff member complains -- I'm talking about a medical staff member complains to the director of nursing about something that another staff member did or did not do pertaining to patient care, is that something that the DON -- is it okay for the DON to not pass that on to the health services administrator?

A. I think it depends on what it is.

Q. If the medical technician is passing out meds and sees Sindi Spray not being able to walk, and having to have aid in scooting her back to her bunk, and complaining of abdominal pain and burning, if she reports it to the nurse, in this case nurse Hadden, should nurse Hadden

simply refuse to go see her?

A. You're not allowed to just refuse to see someone. You're obligated to make sure that that patient's had an assessment. So depending on circumstances, the patient may have just had an assessment, or they may have a -- an assessment scheduled like in the next few hours. So to answer your question, you can't just ignore a patient.

Q. You didn't see anything -- and I appreciate that. You didn't see anything for a scheduled assessment in the next few hours, did you?

A. I did not. But what I was trying to articulate is that you can't ignore a patient. Your obligation is to make sure that that patient has been assessed and has a treatment plan in place.

Q. Did you see the videos of approximately 9:00 a.m. or 9:20 a.m. on December 16th showing that Sindi Spray was walking to a breathing treatment that morning?

A. The video I remember, and I think this is the one that has been mentioned, I saw where she slid down the wall.

Q. I'm talking about one before that.

A. I don't remember that one offhand.

Q. Okay. You saw the one where she slid down the wall?

the cell mate Kim Darling gave to local news media?

A. I want to say that I remember pieces of that. I'm afraid I don't remember much of it.

Q. I just wondered if you reviewed it.

A. I think so. I don't exactly remember.

Q. Did it affect any of your opinions?

A. No.

Q. You noted at page 6 of your report on the Pottawatomie County Jail that there was no obvious -- or there was no reference to any obvious pain or any medical problems at that time on December 12th. That's your belief, right?

A. That's what I had documented.

Q. On page 7 under the heading of Oklahoma County Jail, line 8 says December 12, 2018, pre-booking screening. Where did you get that from, since she wasn't there on December 12th?

Doctor, I don't know if we have enough time for you to go through all that. Would you at least acknowledge she wasn't there on December 12th?

A. She was -- she came on December 13.

Q. Okay. Doctor, on page 8 of your report, there's an excerpt from the chart that you put there.

A. Page 8, sir?

Q. Yes. Toward the bottom, between the 10 and the